

GLOBAL MEDICAL ETHICS

Dealing with ethical problems in the healthcare system in Lithuania: achievements and challenges

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Ethical problems in healthcare in Lithuania are identified, existing mechanisms that deal with them are analysed and policy implications are discussed. At least three groups of ethical problems exist in the Lithuanian healthcare system: problems in the healthcare reform process, in interprofessional interaction and in doctor–patient relationships. During the past 15 years, several diverse legal, political and administrative mechanisms have been implemented in Lithuania to tackle these problems. Despite major achievements, numerous problems persist, implying that the focus should be shifted to different mechanisms and interventions. It is necessary to broaden the conceptual understanding of ethics in healthcare and focus on management ethics to tackle ethical problems in Lithuania or in other countries in transition.

This article identifies ethical problems in healthcare in Lithuania, analyses existing mechanisms to deal with them and discusses policy implications.

ETHICAL PROBLEMS OF HEALTHCARE REFORM

The process of healthcare reform

The World Health Organization Regional Office for Europe outlined three main values as the ethical background for public healthcare: health as a fundamental human right; justice and solidarity among countries, groups and sexes; and participation of people, groups, communities, institutions, organisations and sectors in the process of healthcare promotion.¹ Healthcare reform in Lithuania lacks the active participation of patients and the public. Community participation in policy making is a complex process,² becoming even more so in countries in transition. We identify several interlinked causes for low community participation in policy making. Firstly, the current organisational structure of the healthcare system does not facilitate public participation. When communities have the power to influence public policy, there may be a conflict of interests, which may explain why this organisational structure persists. Secondly, communities themselves are weak because of social problems, and lack of cohesion and traditions of participation. Thirdly, the attitudes of healthcare professionals impede the community development process, because many of them still exercise a paternalistic approach towards patients and users of healthcare services. In general, post-totalitarian societies do not possess the traditional community links that are prevalent in the Western countries, and although eager to accept ideological pluralism, it takes them a long time owing to a lack of this tradition in their political and democratic culture.

In addition, transparency of the reform process is lacking. Consequently, it is not clear to the population why a particular reform or changes have been implemented and why certain decisions have been taken.³ Similar problems were noticed in other countries in transition. A similar lack of communication about healthcare reform in Bulgaria resulted in few people understanding the substantial changes that were under way.⁴

Outcomes of healthcare reform

Among the ethical problems related to the outcomes of healthcare reform in Lithuania are

Lithuania obtained political independence from the Soviet Union in 1990 and joined the European Union in 2004. Since attaining political independence, Lithuania, with the aim of becoming a democratic country, has introduced numerous reforms.

Radical changes made during the transitional period in Lithuania have had effects on the entire society, including on the healthcare system. Lithuania inherited a centralised healthcare system, oriented towards disease and hospital care, in the beginning of the 1990s. The objectives of healthcare reform included strengthening primary healthcare, reducing hospital capacity, implementing a social health insurance system and improving the quality of healthcare services. A new model of healthcare system management, with clearly defined responsibilities, needed to be developed to achieve these tasks.

The Lithuanian healthcare sector has been facing problems, some of which are inherited, such as a paternalistic approach towards patients and unofficial payments, and some that have occurred as a result of technology, privatisation and other modern trends in healthcare. It is possible to distinguish three groups of problems at all levels of the Lithuanian healthcare system: problems of healthcare reform, those of interprofessional interaction and in relationships between doctors and patients. This classification is arbitrary because these problems overlap, but it illustrates the scope of the situation.

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health inequalities, inadequate access to services and lack of trust in the healthcare system.

Despite efforts to reduce them, regional, social and economic inequalities have been reported in Lithuania.⁵ Problems exist in accessing healthcare services: 52.8% of respondents said that laws on their right to healthcare services have not been implemented.⁶ During the past 15 years, healthcare system reforms have thrown up several challenges. Primary healthcare reform in Lithuania started in the mid-1990s, but has not been completed. The institution of the general practitioner is not comprehensive and cannot solve the major part of the problem in healthcare. As a consequence, primary healthcare reform did not reduce the demand for inpatient services or overall costs. In parallel, the continuous functioning of an extensive network of inpatient institutions leads to a lack of efficiency in the system. We argue that a major reason for this situation is not the lack of funding, as is often claimed, but organisational and administrative issues.

The role of trust in the effectiveness of medical care has been emphasised by scholars.^{7,8} Lack of trust prevails at all levels of the Lithuanian healthcare system, whether institutional or between doctor and patient. Results of Peičius's⁶ study showed that 26.0% of respondents of a representative sample of the population lack trust in the Lithuanian healthcare system.

ETHICS OF INTERPROFESSIONAL RELATIONSHIPS

Interprofessional relationships include communication with and cooperation among healthcare and social workers, which are crucial to the extensive teamwork required by modern healthcare. The ethical problems of interprofessional relationships in healthcare, such as high professional insecurity and a poor capacity for teamwork, and the low prestige of the medical profession, result in the lack of social trust and also hostility among healthcare workers.

According to a survey of 834 healthcare workers, 69.0% believed that future government plans would make their situation worse and 43.2% feared that they may lose their job in a year.⁹

Healthcare workers do not have incentives for professional performance and their salaries are lower than the average salaries in the country. Owing to the low salaries of doctors, pharmaceutical companies are convincing them to prescribe their drugs by offering them gifts that they cannot otherwise afford, such as trips. This practice neglects the interests of the patients. The negative influence of pharmaceutical companies on doctors is interconnected to the low prestige of the medical profession.

Difficulties in interprofessional relationships at the organisational level occur because of a lack of information technology and unified databases and the complicated administrative structure of the healthcare system. Frequent misunderstandings arise from the lack of exchange of information between general practitioners and specialists, and between medical and social workers. Among the major problems reported is the limited interaction between healthcare professionals working in the same organisation.¹⁰

ETHICAL PROBLEMS OF DOCTOR–PATIENT RELATIONSHIPS

The main ethical problems in doctor–patient relationships in the Lithuanian healthcare system include a paternalistic approach towards patients and unofficial payments.

Prevalence of the paternalistic approach in the behaviour of doctors to patients is widely reported, when doctors do not treat patients as people and prefer to order them rather than giving them information. According to a cross-sectional study conducted on a small community, 63.6% of respondents

believed that doctors do not treat all patients equally.¹¹ The most common complaints of healthcare users were about the attitudes and skills of doctors.¹² Similarly, general practitioners did not always consider the personal values of patients, such as financial responsibilities (44.1%) and lifestyle (46.8 %). This situation limits the possibilities of the healthcare users participating in tackling health problems and becomes the cause of potential conflicts between doctors and patients.⁶ The quality of a clinical relationship with patients depends largely on trust towards doctors, and a paternalistic approach towards patients leads to reduced trust towards doctors.

The phenomenon of charges for legally free healthcare is prevalent in Lithuania as in other post-communist countries.¹³ The existence of an extensive tradition of gift giving was recognised in the Soviet literature.¹⁴ It should be emphasised that charging for legally free healthcare is a major economic problem.¹⁵ The existence of informal payments is *prima facie* evidence that publicly set prices are insufficient to induce supply, and that the threats of sanctions against providers who do not offer services at these prices are insufficient. The appropriate response for governments is to set producer prices, but in times of budgetary squeeze and excess capacity this is not easy. Without wholesale rationalisation of supply, informal payments will continue to play a major part in resource allocation, and negative effects on equity and access will continue.¹⁶ In Lithuania, recently implemented steps towards this management model are higher official prices for general practitioner services and fewer patients registered with general practitioner.

MECHANISMS THAT AIM AT DEALING WITH ETHICAL PROBLEMS IN LITHUANIA

Decentralisation

Decentralisation can achieve higher accountability, efficiency and democracy, among other goals. In Lithuania, decentralisation reform started in the early 1990s and resulted in three tiers of administrative structure: national, regional and municipal. The current administrative structure is supposed to be more democratic, as citizens can express their opinion every 4 years through democratic elections and this way influence public policy.

Decentralisation in the Lithuanian healthcare sector resulted in newly established administrative and funding entities at local levels, such as municipal boards of public health, municipality health funds and municipality and county doctors. According to legislation, the municipal boards of public health are responsible for developing and implementing primary healthcare in their municipalities. Municipality health funds are the main source of financing municipal public healthcare programmes. Responsibilities of municipal and county doctors include strengthening primary healthcare and public health and implementing national healthcare policy at municipal and regional levels.

In Lithuania, municipalities are the owners of most hospitals and municipality boards take decisions with regard to closing or restructuring hospitals. The board members are often not willing to take unpopular decisions, such as closing a hospital in their municipality, as they are elected in the same municipalities and the opinions of voters are important to them. This organisational structure has impeded hospital restructuring reform in Lithuania. Attempts to change this situation have failed. The intention to transfer the ownership of the hospitals to counties, where decision makers are appointed and not elected, faced strong resistance from the association of municipalities. Consequently, a decision was taken to create committees on restructuring healthcare institutions at the county level.¹⁷

Many organisational and planning issues in healthcare depend on decisions taken at the municipality level, according to legislative regulation of municipal institutions. Every municipality should have a municipality board of public health to coordinate programmes on health promotion, alcohol and tobacco control and other public healthcare issues. This board has one third of its representatives from non-government organisations, to encourage public participation in policy making. In addition, each municipality is expected to create municipality health funds to stimulate the financing of public healthcare programmes.

Legislation authorises municipalities to have powers associated with healthcare, but several challenges remain with regard to the role of the local government. For example, most municipalities have not established their municipality boards of public health and are not willing to strengthen the position of municipal physicians. In addition, politicians and communities at the municipal level lack knowledge and information on health policy issues and their opinion is strongly affected by the media.¹⁷

Legal mechanisms

Legislation in healthcare has been a common regulatory mechanism in dealing with ethical problems in Lithuania. Healthcare policy and legislation of patients' rights are strongly based on principles of ethics, such as equity, justice, human rights and dignity. For example, the Lithuanian Health Program of 1998 includes the objective of reducing socioeconomic inequalities in health.¹⁸ The law on the healthcare system emphasises public participation and equity.¹⁹ The law on a patient's rights, adopted in 1997, stipulated patients' right to information, to complain and to choose the healthcare provider and institution.²⁰ Recent amendments to this law included compulsory insurance for healthcare institutions to insure sufficient resources to compensate any harm done to patients' health. The law on mental health, adopted in 1999, stipulated the rights of patients with mental disorders according to ethical principles, such as dignity and equity.

The implementation of laws is a complicated process and requires resources, time and the fulfilment of preconditions necessary for legislation to function in a specific country. A major proportion of Lithuanian respondents from a representative sample believed that patients' rights had not been implemented, and more than 40% said that the rights to information and privacy had not been implemented.⁶

Institutional mechanisms

During the past decade, several institutions were created in Lithuania, which have been dealing directly or indirectly with ethical problems. Of them, we will describe the National Health Board, the Lithuanian Bioethical Committee, the State Medical Audit, Clinical Ethical Committees (CECs) and the observatory boards of healthcare institutions.

- The National Health Board is an advisory body on health policy to the Lithuanian Parliament and seeks to improve the health of the population and ensure the cooperation of local and national institutions.
- The Lithuanian Bioethical Committee was founded by the Ministry of Health and aims to implement bioethical principles in healthcare policy and educate healthcare professionals and the community in bioethics.²¹
- The primary objective of the State Medical Audit, which was created in 1997, is to analyse patients' complaints and take appropriate actions. The growing role of this institution in ethical and legal aspects of healthcare is reflected in the increasing number of patients' complaints. The number of complaints almost doubled during the past

8 years, from 140 in 1997 to 217 in 2004.²² The main reasons for patients' complaints were the quality of, and access to, healthcare services.

- The CECs should provide input into policy and guidelines and education, and advice on individual cases.²³ It is mandatory for big hospitals in Lithuania to have CECs. Traditionally, the tasks of CECs included listening to complaints about dishonest or inappropriate behaviour of colleagues or other members of the organisation and establishing corresponding sanctions. Currently, most CECs in Lithuania do not contribute to the improvement of hospital management or development of ethical codes for hospitals.¹⁰ Similar challenges were reported in other countries in transition, where CECs were concerned almost exclusively with approval of research protocols and their members did not have the knowledge and skills that would be useful for the other functions.²⁴
- The activities of the observatory boards of healthcare institutions are stipulated by the law of 1998.²⁵ The main objective of these boards is to encourage public participation in management by including representatives of the community and professional unions. Their activities are rather formal because of deficiencies in the work of board members and legislative discrepancies, the lack of active participation from the community, the particularities of providing medical services and others.²⁶

DISCUSSION

During the past 15 years, Lithuania has implemented several diverse legal, political and administrative mechanisms to deal with ethical problems in healthcare. Despite major achievements, several problems persist, including inequity, injustice, unethical behaviour of healthcare workers and others. Several hypotheses attempt to explain this situation.

Most interventions were legislative and required several preconditions to be fulfilled, such as adequate resources and strong institutions. Countries in transition, including Lithuania, are relatively "weak" in terms of their institutional capacity.^{16, 27} As a result, these countries have difficulties in implementing and monitoring legislation. In addition, legislative means are not effective in changing patterns of behaviour. Mechanisms aiming to increase public participation and achieve more democracy were not very successful owing to lack of traditions of civil participation, social cohesion and networks.

An important factor underlying this situation relates to the conceptual understanding of ethics. In Lithuania, ethics has often been perceived as the polite or good behaviour of healthcare personnel and has been measured according to abstract humanitarian principles. In this context, neither managers nor healthcare professionals view the correlation between ethics and the outcomes of healthcare. When ethics is "measured" according to the consequences of actions, then interlinks between ethics, quality, morality and efficiency become obvious and yields responsibility for the actions (eg, poor performance, illegal payment). If healthcare professionals understood that low-quality healthcare equals unethical healthcare, many problems in the healthcare system in Lithuania (and in other countries in transition) would not occur at all.

A broader concept of ethics leads to comprehension about the importance of organisational and management ethics. The role of institutions has been growing. An organisational change in healthcare was called "the key to quality improvement".²⁸ To provide high-quality care efficiently, the organisation has to integrate its organisational functions, professional groups and specialist workers into one coherent effort.²⁹ In the meantime, little has been achieved in this

domain in Lithuania. Organisational ethics is not the sum of the “good behaviour” of personnel but is a complex combination of functional interactions, network of structures and functions, and combinations of roles that can deal with the needs of society in a responsible manner. Organisational ethics requires the transferring of decisions to the organisational level and making them part of institutional responsibility.

The role of management of healthcare institutions was emphasised in dealing with informal payments and the lack of trust. To reduce informal payments, the regulation and governance of the healthcare institutions and professionals should change, as simply increasing public budgeting will not eradicate the problem.^{14 30} Institutions are crucial in implementing policies aiming to increase social trust.³¹

CECs can contribute more in dealing with ethical problems of healthcare management. CECs should respond to current demands and modify their functions and responsibilities. Functions of these committees should include providing preliminary solutions to problems and prevention of these problems, development of constructive measures to solve problems at the organisational level and recommendations on strengthening trust between healthcare providers and doctors and on improving the image of the organisation. Supportive institutions are crucial to the success of CECs. CECs can function effectively only when institutional structures are in place to ensure that their recommendations can be practically implemented.³²

Traditionally, ethics has dealt with issues related to values in society. Modern ethics calls for effective and innovative interventions and requires a specific approach to challenges in countries in transition.

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